STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G606	A. BUILDING	00	COMPLETED 09/16/2013
		133000	B. WING		09/10/2013
NAME OF F	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CODE 5 GREENHILLS LN S	
REM-IND	DIANA INC			ANAPOLIS, IN 46222	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	·	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE
TAG W000000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
VV000000					
	This visit was fo	or the investigation of	W000000)	
	complaint #IN0	_			
	F				
	Complaint #IN(00135534: Substantiated,			
		e deficiencies related to			
) are cited at: W102,			
	W104, W122, V	W149, W154, W158,			
	W159 and W18	6.			
	Unrelated deficiencies cited.				
	Dates of Survey	<i>y</i> : 9/9/13, 9/10/13, 9/11/13,			
	9/12/13 and 9/1	6/13.			
	Facility Numbe				
	Provider Numb	er: 15G606			
	AIMS Number:	100245640			
	Surveyor:				
	Keith Briner, Q	IDP			
		ies also reflect state			
	I -	ordance with 460 IAC 9.			
		completed 9/26/13 by			
	Ruth Shackelfor	rd, QIDP.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00		
		15G606	B. WIN	G		09/16/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
			3025 GREENHILLS LN S				
REM-IND	DIANA INC			INDIA	NAPOLIS, IN 46222		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000102	483.410 GOVERNING BO The facility must e governing body an requirements are Based on record facility failed to a Participation: Go sampled clients (additional client failed to exercise and operating dir ensure the facility and procedures to regarding superv immediately noti Developmental II accordance with incident of client regarding clients allegation of abu and ensure the fa thorough investig incident of client clients A and D, client aggression and E and three s	DY AND MANAGEMENT ensure that specific and management met. review and interview, the meet the Condition of everning Body for 4 of 4 A, B, C and D) plus one (E). The governing body a general policy, budget rection over the facility to by implemented its policy	WO		The Home Manager and Prog Director will be retrained on ensuring appropriate staffing levels are in place for each clius specifically. This includes, but not limited to, staffing in a way ensure the Behavior Support Plans are able to be appropriate implemented. Ongoing, the Ho Manager and Program Director will ensure that the appropriate staffing is in place for each clie Addendum- Starting on 10/16/2013 An Administrative staff will complete 2 weekly observations for four weeks. At the four weeks, the administrates staff will continue with no less than one weekly observation ongoing, to ensure that appropriate staffing is in place Direct Care Staff will be retrained in Indiana MENTOR's reporting procedures, including but not limited to abuse, neglect, and exploitation, and all other reportable incidents according BDDS. The Home Manager and Program Director will be retrained.	ram ent is to ately me or e ent. After tive	
	The section 1	- 4 C-:1- 4 4			on Indiana MENTOR's reporting	ng	
		ody failed to exercise			procedures, including but not		
	1 1	udget and operating			limited to abuse, neglect, and exploitation, and all other		
		e facility to ensure the			reportable incidents according	to	
		Intellectual Disabilities			BDDS.Ongoing, the Direct Ca		
	, , , , , , , , , , , , , , , , , , ,	ordinated client A's BSP			Staff, Home Manager, and		
	(Behavior Suppo	rt Plan) regarding			Program Director will ensure t	nat	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HIKE11

Facility ID: 001175

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET			COMPLETED
		15G606	A. BUI. B. WIN			09/16/2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	2			REENHILLS LN S	
REM-IND	DIANA INC				APOLIS, IN 46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	restitution for pr	operty destruction of a			all incidents, according to BDD	
	neighbor's windo	ow, monitored clients A,			are reported appropriately and	•
	B, C and D's pro	grams in regard to			correctly. Addendum- Starting 10/16/2013 An Administrative	on
		collection, ensured			staff will complete 2 weekly au	dits
	clients A, B, C a	· ·			of the books for four weeks. At	
		Functional Assessments)			the four weeks, the administra	•
		nnually and to ensure			staff will continue with no less	
		•			than one weekly audit, ongoing	- 1
	_	uate staff levels to			to ensure that no incidents ren	
	implement clien	t A's BSP.			unreported. The Program Dire will be retrained on Indiana	ctor
					MENTOR's policy and	
	Findings include	: :			procedures on Investigations.	
					This includes, but is not limited	i to
	1. The governing	g body failed to exercise			what needs to be investigated,	,
	general policy, b	oudget and operating			and how to complete	
		e facility to ensure the			investigations.Ongoing, the	
		nted its policy and			Program Director will ensure the all required investigations are	nat
		event neglect regarding			completed accurately,	
	1	lient A, to immediately			appropriately, within the correct	et
					time frame, and according to	
	_	accordance with state law			Indiana MENTOR's	
		ident of client to client			policy.Ongoing, all investigatio	ns
		ding clients A, D and E			will be reviewed by the Area	
	_	n of abuse regarding client			Director and/or the Quality Assurance Manager for accura	acv
	D, and ensured t	he facility completed a			and recommendations.Please	ж
	thorough investi	gation regarding an			also see W104.The Home	
	incident of clien	t to client aggression for			Manager and Program Directo	r
		an incident of client to			will be retrained on ensuring	
		regarding clients A, D			appropriate staffing levels are	•
		separate incidents of			place for each client specifical This includes, but is not limited	
		g elopement for client A.			staffing in a way to ensure the	
	Please see W104				Behavior Support Plans are at	•
	1 Icase see W 102	r.			to be appropriately	
		1 1 6 1 1			implemented.Ongoing, the Ho	
		g body failed to meet the			Manager and Program Directo	
		ticipation: Client			will ensure that the appropriate	•
	Protections. The	governing body failed to			staffing is in place for each clie	ent.

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Event ID: HIKE11

Facility ID: 001175

If continuation sheet Page 3 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	DING	00	COMPLETED		
		15G606		A. BUILDING B. WING			3	
			В. W II V		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				REENHILLS LN S			
REM-INC	DIANA INC				APOLIS, IN 46222			
					711 OLIO, 11 1 40222			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE CO	MPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	exercise general	policy, budget and			Addendum- Starting on			
	operating direction	on over the facility to			10/16/2013 An Administrative			
	ensure the facilit	y implemented its policy			staff will complete 2 weekly observations for four weeks. A	ftor		
		o prevent neglect			the four weeks, the administra			
	-	rision of client A, to			staff will continue with no less	ave		
		ify BDDS in accordance			than one weekly observation			
					ongoing, to ensure that			
		garding an incident of			appropriate staffing is in place.			
	·	ggression regarding			Direct Care Staff will be retrain			
	clients A, D and	E and an allegation of			on Indiana MENTOR's reportir	ng		
	abuse regarding	client D, and ensured the			procedures, including but not			
	facility complete	ed a thorough			limited to abuse, neglect, and exploitation, and all other			
	1 -	arding an incident of			reportable incidents according	to		
		ggression for clients A			BDDS.The Home Manager and			
	·	nt of client to client			Program Director will be retrain			
					on Indiana MENTOR's reportir			
		ding clients A, D and E			procedures, including but not			
	_	te incidents of neglect			limited to abuse, neglect, and			
	regarding elopen	nent for client A. Please			exploitation, and all other			
	see W122.				reportable incidents according			
					BDDS.Ongoing, the Direct Car Staff, Home Manager, and	e		
	3. The governing	g body failed to meet the			Program Director will ensure the	nat		
		ticipation: Facility			all incidents, according to BDD			
		verning body failed to			are reported appropriately and			
		- ·			correctly. Addendum- Starting	on		
		policy, budget and			10/16/2013 An Administrative			
	1 2	on over the facility to			staff will complete 2 weekly au			
	`	coordinated client A's			of the books for four weeks. At			
		estitution for property			the four weeks, the administration staff will continue with no less	live		
	destruction of a 1	neighbor's window,			than one weekly audit, ongoing	,		
	monitored clients	s A, B, C and D's			to ensure that no incidents ren			
		rd to measurable data			unreported. The Program Dire			
		sure clients A, B, C and			will be retrained on Indiana			
	· ·	eviewed annually and to			MENTOR's policy and			
					procedures on Investigations.			
		e adequate staff levels to			This includes, but is not limited			
	-	A's BSP. Please see			what needs to be investigated,			
	W158.				and how to complete			

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Event ID: HIKE11

Facility ID: 001175

If continuation sheet Page 4 of 71

PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G606	A. BUILDING B. WING	COMPLETED 09/16/2013					
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, ST 3025 GREENHILLS LI	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULI REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECT CROSS-REFEREN DI	S PLAN OF CORRECTION ITVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFFICIENCY) (X5) COMPLETION DATE					
	This federal tag relates to complaint #IN00135534. 9-3-1(a)	Program Dire all required in completed ac appropriately, time frame, a Indiana MEN' policy. Ongoin will be review Director and/o Assurance Mand recomme also see W12 Director will be correctly imple Behavior Supwritten for easpecifically the The restitution previously impompleted. Or Director will in the way the terminate Program Director will in the way the terminate Care Staff, as BSP is completed. Care Staff, as BSP is completed. Or 10/16/2013 A staff will compobservations the four week staff will contitude on easperopriate staff. The Home Maretrained on easperopriate on easperopriate and contelled in the monthly data are located in	within the correct and according to TOR's and according to TOR's and all investigations are by the Area for the Quality anager for accuracy andations. Please 22. The Program are retrained on the ementing the apport Plan specifically and the propert Plan specifically are restitution portion. In plan that was not plemented will be angoing, the Program amplement all BSP are intended. The actor will also ensure training is available and with the Direct are to ensure that the altered correctly at all addum- Starting on an Administrative plete 2 weekly for four weeks. After as, the administrative inue with no less ackly observation ansure that traffing is in place. anager will be					

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Event ID: HIKE11

Facility ID: 001175

If continuation sheet

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PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 09/16	LETED	
	PROVIDER OR SUPPLIER		STREET . 3025 G	ADDRESS, CITY, STATE, ZIP CODE GREENHILLS LN S JAPOLIS, IN 46222	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE PRIATE	(X5) COMPLETION DATE
				tracking, and documenting goal being ran. This include working with the Program E to ensure that new goal track sheets are placed in the ho the beginning of each month. Ongoing, the Progra Director and Home Manage ensure that the goal trackin sheets are located in the hot throughout the duration of t month. Addendum- Starting 10/16/2013 An Administrati staff will complete 2 weekly of the books for four weeks the four weeks, the administrating that all goal track sheets are made available staff, are completed, and documented correctly. The Program Director will be reton completing Comprehens Functional Assessments are ensuring that they do not extend they are available at all time reference. Ongoing, the Prodirector will ensure that all are completed in a timely mand are available when needed. Addendum- Starting 10/16/2013 An Administrati staff will complete 2 weekly of the books for four weeks the four weeks, the administratif will continue with no let than one weekly audit, ongoto ensure that current CFAstarting to ensure that current CFAstarting to ensure that current CFAstarting that the program current CFAstarting that the prog	es director cking me at mer will gome he on ve audits . After strative ss bing, ing to the rained sive id kpire. ese that es for gram CFA's nanner gon ve audits . After strative ss bing, ingular characteristics on the saudits . After strative ss bing,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HIKE11

Facility ID: 001175

If continuation sheet

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PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G606	A. BUILDING B. WING	00	COMPLETED 09/16/2013			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	DIANA INC		3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				included and completed. The Home Manager and Program Director will be retrained on appropriate staffing levels according to each client's need including but not limited to, meeting the needs of each Behavior Support Plan. Ongoi the Home Manager and Progr. Director will ensure that the appropriate staffing is in place each client. Addendum- Startin on 10/16/2013 An Administratistaff will complete 2 weekly observations for four weeks. At the four weeks, the administratistaff will continue with no less than one weekly observation ongoing, to ensure that appropriate staffing is in place Please see W158. Completion Date: October 16, 2013Responsible Party: Home Manager, Program Director, a Area Director	ng, am for ng ive ofter tive			

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		15G606	A. BUII B. WIN			09/16/	2013
			b. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	IANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	L	DATE
W000104	483.410(a)(1) GOVERNING BO	DDY					
		dy must exercise general doperating direction over					
		review and interview for	$ _{W0}$	00104	W104The Home Manager and		10/16/2013
		lients (A, B, C and D)			Program Director will be retrain		
	plus one addition	* * * *			on ensuring appropriate staffin	g	
	•	failed to exercise general			levels are in place for each clie specifically. This includes, but		
		nd operating direction			not limited to, staffing in a way		
		to ensure the facility			ensure the Behavior Support		
	•	policy and procedures to			Plans are able to be appropriately		
	•	regarding supervision of		implemented. Ongoing, the Home Manager and Program Director			
	client A, to immediately	0 0 1			will ensure that the appropriate		
	· ·	lopmental Disabilities			staffing is in place for each clie		
	*	ordance with state law			Addendum- Starting on		
	regarding an inci	dent of client to client			10/16/2013 An Administrative staff will complete 2 weekly		
	aggression regard	ding clients A, D and E			observations for four weeks. A	fter	
	and an allegation	of abuse regarding client			the four weeks, the administra	tive	
	D, and ensure the	e facility completed a			staff will continue with no less		
	thorough investig	gation regarding an			than one weekly observation ongoing, to ensure that		
	incident of client	to client aggression for			appropriate staffing is in place	. All	
		an incident of client to			Direct Care Staff will be retrain	ed	
	· · · · · · · · · · · · · · · · · · ·	regarding clients A, D			on Indiana MENTOR's reportir	ng	
		separate incidents of			procedures, including but not limited to abuse, neglect, and		
		g elopement for client A.			exploitation, and all other		
					reportable incidents according		
	The governing be	ody failed to exercise			BDDS. The Home Manager ar		
		udget and operating			Program Director will be retrain on Indiana MENTOR's reportir		
		e facility to ensure the			procedures, including but not	ıy	
		Intellectual Disabilities			limited to abuse, neglect, and		
		ordinated client A's BSP			exploitation, and all other		
	, , , , , , , , , , , , , , , , , , ,	ort Plan) regarding			reportable incidents according		
	`	operty destruction of a			BDDS. Ongoing, the Direct Ca Staff, Home Manager, and	ie	
	•	ow, monitored clients A,			Program Director will ensure the	nat	
	1101511001 5 WIIIUC	,, monitored enems 11,				-	

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RUII DING 00			COMPLETED	
		15G606	A. BUILDING B. WING 09/16/2013			2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					REENHILLS LN S		
REM-INL	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	B, C and D's pro	grams in regard to			all incidents, according to BDD	OS,	
	measurable data	collection and ensured			are reported appropriately and		
	clients A, B, C a				correctly. Addendum- Starting	on	
					10/16/2013 An Administrative		
	` *	Functional Assessments)			staff will complete 2 weekly au		
	were reviewed a	nnually.			of the books for four weeks. At		
					the four weeks, the administra staff will continue with no less	uve	
	The governing b	ody failed to exercise			than one weekly audit, ongoing	a	
		oudget and operating			to ensure that no incidents ren	•	
		e facility to ensure there			unreported. The Program Dire		
		•			will be retrained on Indiana		
	•	aff levels to implement			MENTOR's policy and		
	client A's BSP.				procedures on Investigations.		
					This includes, but is not limited	d to	
	Findings include	:			what needs to be investigated	,	
	-				and how to complete		
	1 The governing	g body failed to exercise			investigations. Ongoing, the		
	,	•			Program Director will ensure the	nat	
		oudget and operating			all required investigations are		
		e facility to ensure the			completed accurately,	-4	
		nted its policy and			appropriately, within the correctime frame, and according to	J.	
	procedures to pr	event neglect regarding			Indiana MENTOR's		
	supervision of cl	ient A, to immediately			policy.Ongoing, all investigation	ns	
	_	accordance with state law			will be reviewed by the Area		
		ident of client to client			Director and/or the Quality		
					Assurance Manager for accura	асу	
		ding clients A, D and E			and recommendations. Please	;	
		n of abuse regarding client			also see W149.The Program		
	D, and ensure th	e facility completed a			Director will be retrained on		
	thorough investi	gation regarding an			correctly implementing the		
	incident of clien	t to client aggression for			Behavior Support Plan specific	cally	
		an incident of client to			written for each Client A,	00	
	·	regarding clients A, D			specifically the restitution porti The restitution plan that was n		
					previously implemented will be		
		separate incidents of			completed.Ongoing, the Progr		
	neglect regarding	g elopement for client A.			Director will implement all BSF		
	Please see W149).			the way the team intended. Th		
					Program Director will also ens		
	2. The governing	g body failed to exercise			that ongoing training is availab		

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Event ID: HIKE11

Facility ID: 001175

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DINC	00	COMPL	ETED
		15G606		LDING		09/16/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
DEM INIE	NAMA INIO		3025 GREENHILLS LN S				
REM-INL	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	general policy,	budget and operating			and completed with the Direct	•	
	1 3,	he facility to ensure the			Care Staff, as to ensure that the	ne	
		•			BSP is completed correctly at	all	
		ted client A's BSP			times.Addendum- Starting on		
		ution for property			10/16/2013 An Administrative		
	destruction of a	neighbor's window,			staff will complete 2 weekly		
	monitored clier	ats A, B, C and D's			observations for four weeks. A		
		gard to measurable data			the four weeks, the administra	tive	
	1 2	•			staff will continue with no less		
		ensured clients A, B, C and			than one weekly observation	D-	
		reviewed annually. Please			ongoing, to ensure that all BSI		
	see W159.				are being utilized and complet	eu	
					appropriately. The Home Manager will be retrained on		
	3 The governing	ng body failed to exercise			ensuring that monthly data		
		budget and operating			collection sheets are located in	า	
	1 2				the home, and that staff are	1	
		he facility to ensure there			appropriate running, tracking,	and	
	were adequate	staff levels to implement			documenting each goal being		
	client A's BSP.	Please see W186.			This includes working with the		
					Program Director to ensure the		
	This federal tag	relates to complaint			new goal tracking sheets are		
	#IN00135534.	, relates to complaint			placed in the home at the		
	#INUU133334.				beginning of each		
					month.Addendum- Starting on		
	9-3-1(a)				10/16/2013 An Administrative		
					staff will complete 2 weekly au		
					of the books for four weeks. A		
					the four weeks, the administra	tive	
					staff will continue with no less	_	
					than one weekly audit, ongoin to ensure that all goal tracking		
					sheets are made available to t		
					staff, are completed, and	.110	
					documented correctly. Ongoin	a.	
					the Program Director and Hon	-	
					Manager will ensure that the g		
					tracking sheets are located in		
					home throughout the duration		
					the month.The Program Direct		
					will be retrained on completing		
					Comprehensive Functional		
					-		

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PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G606	A. BUILDING B. WING	00	COMPLETED 09/16/2013		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
				Assessments and ensuring that they do not expire. This retrain will include appropriately completing these assessment and ensuring that they are available at all times for reference. Ongoing, the Prograd Director will ensure that all CF are completed in a timely man and are available when needed. Please also see W159The Home Manager and Program Director will be retrain on appropriate staffing levels according to each client's need including but not limited to, meeting the needs of each Behavior Support Plan. Ongoon the Home Manager and Program Director will ensure that the appropriate staffing is in place each client. Addendum- Starting on 10/16/2013 An Administratistaff will complete 2 weekly observations for four weeks. At the four weeks, the administratistaff will continue with no less than one weekly observation ongoing, to ensure that appropriate staffing is in place Please also see W186Complet Date: October 16, 2013Responsible Party: Home Manager, Program Director, a Area Director	ning s, am cA's ner I ned ds, ing, am for ng ive ofter tive		

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED		
		15G606	B. WIN			09/16/2013		
NAME OF B	AD CAMPED ON GAMPA IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			3025 G	REENHILLS LN S			
	DIANA INC			INDIAN	IAPOLIS, IN 46222			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
TAG W000122	A83.420 CLIENT PROTECT The facility must oprotections require Based on record facility failed to a Participation: Clisampled clients (additional client implement its poprevent neglect relient A. The facility BDDS (Brotas Disabilities Servistate law regarding client aggression and E and an aller regarding client implement its poprevent neglect regarding client implement its popolicy and procession for client aggression for client regarding clients separate incident elopement for clients. The facility fapolicy and procession group incident of clients regarding include: 1. The facility fapolicy and procession group incident of clients aggression for clients aggression and grants aggression for clients ag	ensure that specific client ements are met. review and interview, the meet the Condition of ient Protections for 2 of 4 (A and D) plus one (E). The facility failed to licy and procedures to regarding supervision of ility failed to implement occdures to immediately ureau of Developmental ices) in accordance with mg an incident of client to regarding clients A, D regation of abuse D. The facility failed to licy and procedures to ugh investigation ident of client to client ients A and D, and to client aggression A, D and E and three as of neglect regarding ient A.	W0	00122	W122All Direct Care Staff will retrained on Indiana MENTOR reporting procedures, including but not limited to abuse, negle and exploitation, and all other reportable incidents according BDDS. The Home Manager ar Program Director will be retrain on Indiana MENTOR's reportir procedures, including but not limited to abuse, neglect, and exploitation, and all other reportable incidents according BDDS. Ongoing, the Direct Ca Staff, Home Manager, and Program Director will ensure thall incidents, according to BDD are reported appropriately and correctly. Addendum- Starting 10/16/2013 An Administrative staff will complete 2 weekly au of the books for four weeks. At the four weeks, the administrat staff will continue with no less than one weekly audit, ongoing to ensure that no incidents renunreported. The Program Director will be retrained on Indiana MENTOR's policy and procedures on Investigations. This includes, but is not limited what needs to be investigated, and how to complete investigations. Ongoing, the Program Director will ensure thall required investigations are	to t	10/16/2013	
	•	implement its policy and			completed accurately,			
	procedures to im	mediately notify BDDS			appropriately, within the correct	π		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		15G606	B. WIN			09/16/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹			REENHILLS LN S	
REM-INF	DIANA INC				APOLIS, IN 46222	
					711 0210, 114 10222	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· ·	DATE
		ith state law regarding an			time frame, and according to Indiana MENTOR's	
	incident of clien	t to client aggression			policy.Ongoing, all investigation	ins
	regarding clients	s A, D and E and an			will be reviewed by the Area	
	allegation of abu	se regarding client D.			Director and/or the Quality	
	The facility fails	ed to implement its policy			Assurance Manager for accura	
		to complete a thorough			and recommendations. Please	
		garding an incident of			also see W149 All Direct Care	
		ggression for clients A			Staff will be retrained on Indian MENTOR's reporting procedure	II
		ent of client to client			including but not limited to abu	I
	· · · · · · · · · · · · · · · · · · ·				neglect, and exploitation, and	
	""	ding clients A, D and E			other reportable incidents	
	_	te incidents of neglect			according to BDDS. The Home	e
		nent for client A. Please			Manager and Program Directo	r
	see W149.				will be retrained on Indiana	
					MENTOR's reporting procedul	I
	2. The facility fa	ailed to immediately			including but not limited to abu neglect, and exploitation, and	
	notify BDDS in	accordance with state law			other reportable incidents	all
	_	ident of client to client			according to BDDS. Ongoing,	the
		ding clients A, D and E			Direct Care Staff, Home	
	""	n of abuse regarding client			Manager, and Program Directo	or
	D. Please see W				will ensure that all incidents,	
	D. Please see w	133.			according to BDDS, are report	ed
					appropriately and correctly. Addendum- Starting on	
	1	niled to complete a			10/16/2013 An Administrative	
		gation regarding an			staff will complete 2 weekly au	dits
	incident of clien	t to client aggression for			of the books for four weeks. A	
	clients A and D,	an incident of client to			the four weeks, the administra	tive
	client aggression	n regarding clients A, D			staff will continue with no less	
	and E and three	separate incidents of			than one weekly audit, ongoing	
		g elopement for client A.			to ensure that no incidents ren unreported. Please also see	Idiii
	Please see W154. This federal tag relates to complaint				W153 The Program Director w	vill
					be retrained on Indiana	
					MENTOR's policy and	
					procedures on Investigations.	
	#IN00135534.				This includes, but is not limited	I
					what needs to be investigated	
	9-3-2(a)				and how to complete	

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		IDENTIFICATION NUMBER: 15G606	A. BUILDING B. WING	00	COMPLETED 09/16/2013	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S		
	IANA INC		INDIAN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				investigations. Ongoing, the Program Director will ensure the all required investigations are completed accurately, appropriately, within the correctime frame, and according to Indiana MENTOR's policy. Ongoing, all investigation will be reviewed by the Area Director and/or the Quality Assurance Manager for accurated and recommendations. Please also see W154Completion Data October 16, 2013Responsible Party: Home Manager, Progra Director, and Area Director	ons acy ete:	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		15G606	B. WIN			09/16/	2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000149	The facility must of written policies are mistreatment, new Based on record 2 of 4 sampled conditional client implement its porposed prevent neglect reclient A. The facility policy and pronotify BDDS (B. Disabilities Servistate law regardice client aggression and E and an allow regarding client implement its policy and pronotify BDDS (B. Disabilities Servistate law regardice client aggression and E and an allow regarding client implement its policy and pronotify BDDS (B. Disabilities Servistate law regardice client aggression for client implement its policy and pronotified and incident of client regarding clients separate incident elopement for clients. The facility's lient investigations were supplied by PM. The refollowing:	D. The facility failed to olicy and procedures to ough investigation ident of client to client ients A and D, an at to client aggression a A, D and E and three ats of neglect regarding ient A.	W0	00149	W149Program Director will be retrained on Indiana MENTOR policy and procedures on Investigations. This includes, it is not limited to what needs to investigated, and how to complete investigations, and ensuring that all investigations are thoroughly completed. This includes ensuring that all facture findings correspond with each other, and that all areas are looked into and explored. The Program Director will be retrained on following up on all recommendations made from results of the investigations. Ongoing, the Program Director will ensure that all required investigations are completed accurately, appropriately, within the correct time frame, and according to Indiana MENTOR policy. Ongoing, all investigation will be reviewed by the Area Director and/or the Quality Assurance Manager for accurate and recommendations. Direct Care Staff will be retrained on Indiana MENTOR's reporting procedures, including but not limited to abuse, neglect, and exploitation, and all other reportable incidents according BDDS. The Home Manager ar Program Director will be retrained on Indiana MENTOR's reporting procedures incidents according BDDS. The Home Manager ar Program Director will be retrained on Indiana MENTOR's reporting procedures incidents according BDDS. The Home Manager ar Program Director will be retrained on Indiana MENTOR's reporting procedures incidents according BDDS. The Home Manager ar Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's reporting Program Director will be retrained on Indiana MENTOR's	c's but be s al ned the or acy to ad ned	10/16/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE : COMPL		
		15G606		LDING		09/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110		me agitated and hit his			procedures, including but not		D.III.
		on his left arm by the			limited to abuse, neglect, and		
	shoulder. [Client	A] then left the group			exploitation, and all other reportable incidents according	to	
		the neighbor's house.			BDDS. Ongoing, the Direct Ca		
		see [client A] from the			Staff, Home Manager, and Program Director will ensure to	hat	
		since she was the only was not able to assist			all incidents, according to BDD	OS,	
	_	o the home. Staff was			are reported appropriately and correctly. Addendum- Starting		
		911 for assistance and			10/16/2013 An Administrative		
	police responded	l to assist [client A] back			staff will complete 2 weekly au		
		ne 3/30/13 BDDS report			of the books for four weeks. A the four weeks, the administra		
		PD (Program Director)			staff will continue with no less		
	will investigate t	the incident."			than one weekly audit, ongoing to ensure that no incidents ren		
	The review did r	not indicate			unreported. Completion Date:		
		of a BDDS report for			October 16, 2013Responsible Party: Home Manager, Progra		
		ng the 3/30/13 incident of			Director, and Area Director		
	physical aggress	ion by client A. The					
		ndicate documentation of					
	_	regarding the 3/30/13					
	incident of elope	ement.					
	-RDDS report de	ated 4/9/13 indicated,					
	_	having behaviors with					
	-	rom the group home as					
		y attacking staff and					
	_	client A's] behaviors two					
	staff had to use I	` •					
	"	[client A] by holding					
	_	d. [Client A] was not be receive any bruising					
	_	Client A] has a history of					
	eloping from the						
	1						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		A. BUILDING	00		TE SURVEY 1PLETED 16/2013	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO		
REM-IND	DIANA INC			APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	4/8/13 BDDS re A] then went aft him in the face. any bruising or phitting him." The not indicate does client A's BPRN Report Narrative which indicated, hit roommate's rebleeding. [Client D] lost a received from [client D] and/or incident of physical A. -BDDS report da "[Client A] had a peer and became leave the group of follow where he good of the physical peer and became leave the group of the physical peer a	not indicate if a BDDS report for E regarding the 4/8/13 ical aggression by client ated 7/21/13 indicated, a disagreement with a rupset. Staff saw him home but was unable to was going. Staff called d [client A] 40 minutes ated 7/25/13 regarding the eport indicated, "On a] eloped from the home				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	te survey ipleted 16/2013
	PROVIDER OR SUPPLIEF	<u>I</u>	STREET A 3025 G	ADDRESS, CITY, STATE, ZIP CO REENHILLS LN S APOLIS, IN 46222	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	The 7/25/13 Investigation of the terms of the terms of the watched [clie while he watched [clie while he called the because he was to the time later, matched in the watched [clie while he called the because he was to the watched [clie while he called the because he was to the watched [clie while he called the because he was to the was to the was to the was to the watched with he watched [clie while he called the because he was to the was to the watched was the watched w	estigation indicated, gs: Interview with [DSP Professional) #1]; (1) orking with him on that ir) shift at 6:00 PM; (6) nt A] from the porch he home manager the only staff available; ound [client A] a short ybe 30 minutes." estigation indicated, [DSP #3]; (1) she left PM; (2) She had been				

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606		LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/	ETED	
PROVIDER OR SUPPLIER	<u>l</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
on the door and a history of doin The neigbor (sic started verbally the staff member wife called the palice arrived them back to the police arrived art to his home and While the police [client A] attempstaff were able to	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) windows. [Client A] has g this when he elopes.) became upset and threatening [client A] and r that was present. His colice and staff and [client the group home before d. The neighbor followed group home and verbally threatening. The ad took the neighbor back spoke to him in private. were at the neighbor's oted to elope again but or redirect him into staying the police returned shortly				ATE	(X5) COMPLETION DATE	
afterwards and s needed to stay ir goes on the neig they couldn't pre as this would be -Investigation da 8/23/13 incident [client A] eloped to a neighbor's h The 8/28/13 Inve "Factual Finding #1]: (1) the ot him on that day shift at 9:00 PM snack [client A]	tated that [client A] In the home and that if he hbor's property again, event any negative effects, trespassing." Intel 8/28/13 regarding the indicated, "On 8/23/13 If from the home and went						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
MOLLAN	OI CORRECTION	15G606		LDING	00	09/16/	
			B. WIN		DDDEGG CITY GTATE ZID CODE	55/16/	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
		t approximately 9:40 PM					
	_	A] screaming, 'leave me went to the basement to					
		nappened; (5) [client					
		ss what was wrong, but					
	-	n; (6) he was in the					
		s later when [client A]					
		d bolted out (of) the					
	•	he attempted to grab					
		vent him from leaving but					
		(sic) fast; (8) he					
		A] from the porch while					
	=	M (Home Manager) #1]					
	-	the only staff available:					
		ed [client A] approach a					
	* *	but he did not know					
		vas doing; (10) he					
		A] being chased back to					
	-	ale waving a bat; (11)					
	-	n to the house; (12) the					
	man was very up	oset stating [client A] was					
	pounding on his	door; (13) he would					
	hit [client A] and	the staff if they were					
	found on his pro	perty again; (18) the on					
	call supervisor as	rrived at approximately					
	10:00 PM"						
		estigation indicated,					
	· ·	[DSP #2]; (1) she					
	_	oup home from 2:00 PM					
		on 8/23/13; (2) there					
		nat day and everything					
	was fine when sh	ne left."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CON		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		15G606	B. WING			09/16/	2013
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DEMINIE	NAMA INIC				REENHILLS LN S		
	DIANA INC			IAINA	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		estigation indicated,	1710				DATE
		•					
	"Interview with [HM #1]; (1) she arrived at the home at approximately 9:30						
		were two police officers					
		oort when she arrived; (3)					
		lained that the [neighbor					
		upset; (4) the officers					
		bor #1] had a bat and was					
		rm [client A] and staff					
	_	did have the right to					
	defend himself."						
	detend miniseri.						
	The 8/28/13 Inve	estigation indicated,					
		Evidence does not					
	` ′	ent A] eloped; (2)					
		ts staff responded quickly					
	and appropriatel						
	ara appropriate.	<i>,</i>					
	The facility's Tir	ne Detail form dated					
	1	ewed on 9/11/13 at 8:00					
		's Time Detail form dated					
	1	d DSP #2 worked at the					
	group home from	n 4:00 PM through 11:00					
	PM on 8/23/13.	C					
	The 8/28/13 Inve	estigation did not indicate					
		eviewed the Time Detail					
	1	e DSPs #1 and #2's					
	statements regar	ding DSP #2's presence in					
	_	actions during the					
		as on duty in the home.					
	The 8/28/13 Investigation did not indicate						
		egarding if the staffing					
		ne were adequate to					
		-					<u> </u>

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	A. BUILD		NSTRUCTION 00	(X3) DATE : COMPL 09/16/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	provide client A' supervision.	s identified level of						
	9/10/13 at 9:11 Adated 3/30/13 in ate dinner [client around the living roommate (sic) is roommate the roleave me alone (D] the second timestaff call PD (Pocall (sic) on call (sic) he went to be bang on there (sis scream(ing)." Clad/30/13 indicated then when (sic) leath to [client A] back home." Client A's BPRN "After dinner, [comouth and he state also hit [client Edue to the blow base."	ient A's BPRNN dated d, "Staff call (sic) 911 back house (to) call on 011 came go there (sic). Later they bring him IN dated 4/8/13 indicated, lient A] hit roommate's arted bleeding. [Client A] [Client D] lost a tooth me received from [client						
	`	ndividual Support Plan) dicated the following:						
	-"[Client A] has	a BSP (Behavior Support						

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G606	B. WIN	G		09/16/2013	
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SULLER			3025 GI	REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		1
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		by [agency] on 4/13/11					
		lowing behaviors: Type 1					
		oulsive SIB (Self Injurious					
		propriate sexual behavior,					
		tion, extreme irritability,					
		vacating, physical					
	_	t A] had four significant					
	incidents of elop	ement during August and					
	September 2011	, in which it was					
	determined that	[client A] would need one					
	to one ratio staff	as well as change to his					
	vacating compor	nent."					
	-"Assessment of	pedestrian skills: [client					
	A] requires 24 h	our supervision while out					
	in the communit	y."					
	-"Assessment of	his supervision needs:					
	twenty four hour	supervision."					
	-						
	Client A's Risk I	Management Assessment					
	and Plan (RMAI	P) form dated 11/8/12					
	indicated the fol	lowing:					
		-					
	-"[Client A] does	s have behavioral anger					
		ay not understand					
	consequences to	his actions."					
	•						
	-"[Client A] has	a history of elopement.					
		11: [Client A] elopes					
		nd runs very quickly					
	away from staff.						
	-"[Client A] is co	urrently on one to one					

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
II.DIDIII		15G606		LDING		09/16/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIER				REENHILLS LN S		
	DIANA INC				APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		ing waking hours. This		TAG	,		DATE
	_	effective 10/5/11 and					
	•	intil changed by his IDT					
	•	Team). [Client A] will					
		ne supervision during all					
		th the exception of those					
	hours he spends	-					
	spends						
	Client A's BSP d	lated 2/20/13 indicated					
	the following:						
	-"It is the policy	of Indiana Mentor to					
	prepare a BSP de	esigned to develop and					
	teach adaptive b	ehaviors to [client A] for					
	the purpose of in	nproving his quality of					
	life, independent	ce and meaningful					
	participation in t	he community."					
	-"One on one sta	ffing: Due to an increase					
		cating, [client A] will					
		staffing during waking					
		ne staffing will monitor					
		imes during waking					
		ring [client A's] private					
		room. The one on one					
	staff should pay	special attention to					
	[client A's] mood	d and behavior. If the					
	staff member sus	spects [client A] is getting					
	agitated and his	behavior may escalate,					
	•	ct [client A] to an activity					
		house that does not have					
		outside the home. The one					
		ıld also pay special					
	attention to [client	nt A] when he is near any					

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Event ID: HIKE11

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				ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G606	B. WIN	G		09/16/2013	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	door leading the outside of the home. The						
		ays be closest to the door					
	when in a room	with [client A]."					
	-"Responding to	elopement: Staff should					
	implement the fo	ollowing steps regarding					
	vacating:						
	(1) If the sta	aff member suspects					
	[client A] is gett	ing agitated and his					
	behavior may es	calate, attempt to redirect					
	[client A] to an a	activity in an area of the					
	house that does i	not have direct access to					
	outside the home	2.					
	(2) If staff o	bserves [client A]					
	attempting to lea	ive, prompt him to stop					
	and remain with	in the program area. If					
		s requested, resume the					
		with no further comment.					
		bserves [client A]					
	` ′	ive and he ignores the					
		he staff should use					
	1 1	l physical intervention					
		event [client A] from					
	leaving the home						
	_	s unable to stop [client A]					
		yway, the one on one					
		sponsible for his program					
		im and stay with him to					
		danger. Due to [client					
	_	the location of his home					
		f property damage when					
		ne on one staff member					
		cy approved physical					
		nniques to stop [client A].					

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				(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		15G606	B. WIN			09/16/20)13	
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					REENHILLS LN S			
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE (COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Staff should attempt to keep [client A] away from the road, other homes, property and/or vehicles.							
		ssary, and if additional						
		e, a second staff member						
		ome and assist the one on						
	one staff.							
	, , , =	nt A] and the one on one						
		ght, the additional staff						
	member should a	assist on foot.						
	(5c.) If [client	nt A] and the one on one						
	staff are out of e	yesight, the additional						
	staff should use	the van to find [client A]						
	and his one on or	ne staff to assist.						
	(5d.) If at an	y time [client A] has						
	vacated and two	or more staff are						
	available and in	[client A's] reach they						
	should use agend	cy approved physical						
	intervention tech	niques to stop [client A].						
	(6.) When [c	client A] is contained,						
	escort him to a s	afe location and keep him						
	under observatio	n until you are sure he						
	will not vacate a	gain.						
	(7.) If you a	re unable to catch up with						
	[client A] after to	en minutes, contact the on						
	call supervisor for	or further instructions.						
	(8.) If you d	o not see [client A] leave						
		he on call supervisor as						
		ce he is gone and initiate						
	search procedure	_						
		point [client A] is no						
	longer in eyesight, immediately contact							
	911 and the on c							
		y point [client A]						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G606	A. BUI B. WIN	LDING IG		09/16/	2013
NAME OF I	DDOLUDED OD GUDDI IED		B. WIIV		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIER	<u>C</u>			REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		a home other than the					
		f will call 911 and the on					
	call supervisor."						
		spondence dated 9/10/13					
		9/11/13 at 8:00 AM.					
		spondence dated 9/10/13					
	`	rea Director) #1 and ate had discussed revision					
		to one staffing protocol.					
		spondence dated 9/10/13					
	indicated on 6/2:	•					
		following protocol:					
	impremented the	rono wing protocor.					
	-"We will imple	ment 10 minute visual					
	_	that if [client A] wants					
	alone time, staff	don't have to be in his					
	space but can kn	ow if he is safe and not					
	running."						
		1 1 1 0 4 0 4 0					
		spondence dated 9/10/13					
		9/11/13 at 8:00 AM.					
		spondence dated 9/10/13 documentation of changes					
		0/13 BSP regarding how					
	staff should resp						
	elopement.	ond to enem As					
	Interview with C	Community Neighbor					
		nducted on 9/9/13 at 9:13					
		ed, "Since he, [client A],					
	moved into the r	neighborhood about 2					
	1 -	een running away from					
	the house. He, [c	elient A], goes to houses					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	307.107	
NAME OF I	PROVIDER OR SUPPLIER	L .			REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	T -	e door trying to get in, he's					
		, including mine." CN #1					
	stated, "The staff don't even follow him. They just stand on the porch and watch.						
	1	_					
	l	get him or help." CN #1					
	· ·	y terrifying. It happens at					
	~	our house with our					
		enly [client A] will be					
	- 1	ounding on our doors,					
		alls trying to get inside. It "CN #1 stated, "It seems					
	1	for [client A] to be					
		the neighborhood like					
	_	ars on the street and he					
		g in the streets at night.					
		reet lights so it stays					
		n't know, I mean [street]					
	1 * *	d. If he gets out there, it's					
	1 ~ .	nen asked how often					
	<u>-</u>	o their home or is seen					
		the street at night, CN #1					
	1	f goes in spurts. It will be					
		es and then maybe a					
		th nothing. He seems to					
		ng. I think he's done it at					
	l -	this summer. The last					
		was on 8/23/13. It was					
		er 10:00 PM. [Client A]					
	_	our door trying to get					
	"	to get him to leave but he					
		nd throw himself on the					
		from the home came to					
	_	m." CN #1 stated, "I am					
		ng to get hurt. Someone					
	<u> </u>						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G606		LDING		09/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		if he gets inside their		TAG			DATE
	_	dogs too. Our dogs would					
	attack him if he	_					
		50v					
	CN #2 was inter	viewed on 9/9/13 at 5:45					
	PM. CN #2 state	ed, "We've seen him,					
	[client A] runnin	g through the streets.					
	l `	2012), he was here. He,					
		up on my porch and was					
		loors and screaming. He,					
		anging on the door so					
	hard it broke one	e of the glass panels."					
	DSP #1 was inte	rviewed on 9/9/13 at 6:00					
		ed, " usually work in					
		e 5:00 PM until 11:00					
	_	here about 3 months."					
	When asked if [o	client A] had any					
	behavioral issues	s, DSP #1 stated, "[Client					
		he house. He will run out					
	_	to like the neighbor's					
		indicated he was working					
		ng the 7/20/13 and					
		s of client A's elopement.					
		d he had been working					
		se during both incidents. I saw him leave but I					
	•	e other 7 people. I had to					
		tch him. I called the on					
	_ ~	't leave to follow him."					
		was safe for client A to					
		orhood banging on					
	_	nd windows, DSP #1					
	* *	get angry. Sometimes it					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE SU COMPLET	
THAD TEAM	or condition	15G606	A. BUI B. WIN	LDING		09/16/20	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			3025 GF	REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE (COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		IAG	,		DATE
	happens at night. Maybe like 9:00 PM or 10:00 PM." DSP #1 stated, "The last time						
		ened the man chased him					
		#1 indicated staff should					
	follow client A i	nto the community if he					
	elopes.						
	DSP #4 was inte	rviewed on 9/9/13 at 6:10					
	PM. DSP #4 ind	icated client A has eloped					
		DSP #4 indicated client A					
	should be monite	ored while in the					
	community.						
	DSP #5 was inte	rviewed on 9/9/13 at 6:15					
	PM. DSP #5 stat	ed, "[Client A] should					
	have staff with h	im while in the					
		nen asked if it was safe					
		pproach neighbor's homes					
	at night without "No."	staff, DSP #5 stated,					
	NO.						
	PD (Program Di	rector) #1 was					
	interviewed on 9	0/9/13 at 6:20 PM. When					
	asked if the grou	p home could manage					
		or and keep him safe					
		g his elopement from the					
		#1 stated, "Yes, I think					
	· ·	ere is the potential for					
	-	gerous for him to get out ot sure what people will					
		I how someone may react					
]. We can manage his					
		ave to say that the					
		if he does get out again."					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606			LDING	NSTRUCTION 00	(X3) DATE COMPI 09/16	LETED	
	PROVIDER OR SUPPLIER	<u> </u>	B. WIIN	STREET A	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	PM. AD #1 indihistory of eloperhome. AD #1 in on one to one statindicated she had A's advocate in a client A's supervito one staffing to When asked why protocol had been AD #1 stated, "I we had staffing home quite a bit weren't really do [client A] was do having staff alw thought it might have staff do 10 make sure of his some private time with him." AD #1 BSP dated 2/20/1 to reflect the 6/2 was in the proce #1 indicated staff 2/20/13 BSP to be elopement superimplemented. AD #1 was internal and the staff and the staff and the sure of his some private time with him." AD #1 and the staff and the st	cated client A had a ment from the group dicated client A had been affing ratio. AD #1 d discussed with client June 2013 about changing vision protocols from one of 10 minute status checks. So client A's supervision on considered for revision, at was during a time when changes and I was in the changes and I was in the lient June 2013 about changes and I was in the changes and I was in the changes and I was in the lient between the property of					

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606 A. BUILDING D. WING			COMPLETED 09/16/2013			
			B. WIN		DDDEGG OUTV CTATE ZID CODE	00/10/	20.0
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
1710		A's 2/20/13 BSP and		mo	<u> </u>		DATE
	•	s monitored while in the					
		#1 stated, "No, one staff					
	•	ome cannot implement					
	_	ays if at any point he					
	•	or attempts to enter a					
		d follow and prevent					
		ble." When asked if					
	•	sidered to be at risk					
	while in the com	munity unsupervised,					
	AD #1 stated, "Y	-					
	When asked if el	opement of an individual					
	that results in eva	asion of required					
	supervision as de	escribed in the ISP for					
	health and welfar	re was considered					
	neglect, AD #1 s	tated, "Yes."					
	When asked if in	adequate staff support					
	for an individual	including inadequate					
	supervision with	the potential for					
	significant harm	or injury to an individual					
	was neglect, AD	•					
	When asked if th	ere should be enough					
	_	the group home to					
	•	are and services to that					
		ot injure themselves,					
		property, AD #1 stated,					
		ted if special staffing					
		by client A's ISP/BSP					
	should be provid	ed, AD #1 stated, "Yes."					
	2. The facility's I	BDDS reports and					
	· ·	ere reviewed on 9/9/13 at					
	_	view indicated the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G606		LDING		09/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	following:						
	-RDDS report de	ated 8/29/13 indicated,					
		neeting on 8/26/13,					
		ner reported that [client					
		ly attacked by his					
		t A] on 8/24/13." The					
		eport indicated the date					
	of knowledge of	the allegation of abuse					
	regarding client	D was 8/26/13.					
		viewed on 9/10/13 at					
		1 indicated allegations of					
		nd mistreatment should be					
		S within 24 hours of the					
	l '	ge of the allegation. AD					
		gations of abuse, neglect,					
		ploitation and injuries of should be thoroughly					
	investigated.	should be moroughly					
	mvestigated.						
	The facility's pol	licy and procedures were					
		2/13 at 4:26 PM. The					
	facility's April 2	011 policy and procedure					
	entitled Quality	Risk Management					
	indicated "Indian	na Mentor (parent					
	company) follow	vs the BDDS Incident					
		as outlined in the					
		ards. An incident					
		ows shall be reported to					
		e incident report from					
	prescribed by BI	•					
	_	ual abuse, neglect, or					
	exploitation of a	n individual. An incident					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER			3025 GF	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	adult protective and 2011 policy and "Indiana Mentor completing a thosany event out of jeopardizes the hindividual served April 2011 polici indicated, "Inade individual, inclu supervision, with significant harm individual" was of abuse/neglect	the ordinary which health and safety of any d or other employee." The y and procedure equate staff support for an ding inadequate in the potential for or injury to and included in the definition					

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G606		(X2) MU A. BUIL B. WING	DING G	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/16/2013		
	ROVIDER OR SUPPLIER			3025 G	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRED		TE	(X5) COMPLETION DATE	
W000153	The facility must of mistreatment, in injuries of unknown immediately to the officials in accord through establish Based on record 2 of 4 sampled conditional client immediately not Developmental I accordance with incident of client regarding clients allegation of abute Findings include 1. The facility's linvestigations were following: -BDDS report date: -BDDS report date	review and interview for lients (A and D) plus one (E), the facility failed to ify BDDS (Bureau of Disabilities Services) in state law regarding and to client aggression A, D and E and an ase regarding client D. BDDS reports and ere reviewed on 9/9/13 at view indicated the atted 4/9/13 indicated, having behaviors with rom the group home as y attacking staff and client A's] behaviors two	Woo	00153	W153All Direct Care Staff will retrained on Indiana MENTOR reporting procedures, including but not limited to abuse, negle and exploitation, and all other reportable incidents according BDDS. The Home Manager an Program Director will be retrai on Indiana MENTOR's reporting procedures, including but not limited to abuse, neglect, and exploitation, and all other reportable incidents according BDDS. Ongoing, the Direct Ca Staff, Home Manager, and Program Director will ensure that all incidents, according to BDD are reported appropriately and correctly. Addendum- Starting 10/16/2013 An Administrative staff will complete 2 weekly aud of the books for four weeks. At the four weeks, the administra staff will continue with no less than one weekly audit, ongoin to ensure that no incidents renurreported. Completion Date: October 16, 2013	R's g ct, to d ned ng to re hat DS, i on udits fter tive g, nain	10/16/2013

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 16/2013
	PROVIDER OR SUPPLIER	.	STREET A 3025 G	ADDRESS, CITY, STATE, ZIP CO REENHILLS LN S IAPOLIS, IN 46222	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	4/8/13 BDDS re A] then went aft him in the face. any bruising or p hitting him." The not indicate doce client A's BPRN Report Narrative which indicated, hit roommate's re bleeding. [Client [Client D] lost a received from [c The review did re documentation of clients D and/or incident of physis A. Client A's record 9/10/13 at 9:11 A dated 4/8/13 ind [client A] hit roo started bleeding. E]. [Client D] lo he received from 2. The facility's investigations w	ated 4/9/13 regarding the port indicated, "[Client er [client D], punching [Client D] did not having bain from [client A] e 4/9/13 Investigation did amentation of review of N (Behavior Progress e Note) dated 4/8/13 "After dinner, [client A] mouth and he started that A] also hit [client E]. tooth due to the blow he dient A]." Into tindicate of a BDDS report for E regarding the 4/8/13 ical aggression by client divastred and the started of AM. Client A's BPRNN icated, "After dinner, ommate's mouth and he [Client A] also hit [client est a tooth due to the blow				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		00	COMPI - 09/16	
	PROVIDER OR SUPPLIER DIANA INC	3025 GI	ADDRESS, CITY, STATE, ZIP CO REENHILLS LN S APOLIS, IN 46222	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	following: -BDDS report dated 8/29/13 indicated, "During a team meeting on 8/26/13, [client D's] brother reported that [client D] was physically attacked by his roommate [client A] on 8/24/13." The 8/29/13 BDDS report indicated the date of knowledge of the allegation of abuse regarding client D was 8/26/13. AD #1 (Area Director) was interviewed on 9/10/13 at 12:50 PM. AD #1 indicated allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the date of knowledge of the allegation. 9-3-2(a)				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		15G606	B. WIN			09/16/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REENHILLS LN S		
DEM IND	IANA INC				IAPOLIS, IN 46222		
KEWI-IINL				INDIAN	IAPOLIS, IN 40222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000154	483.420(d)(3) STAFF TREATMI The facility must is alleged violations investigated. Based on record 2 of 4 sampled of additional client complete a thoror regarding an incitaggression for client of client regarding clients separate incident elopement for client regarding clients separate incident elopement for client incident of client separate incident elopement for client incident of client separate incident elopement for client incident of client incident of client incident incident elopement for client incident inciden	ENT OF CLIENTS have evidence that all are thoroughly review and interview for lients (A and D) plus one (E), the facility failed to ough investigation ident of client to client ients A and D, an it to client aggression i. A, D and E and three is of neglect regarding ient A. EDDS (Bureau of isabilities Services) reports were reviewed on 9/9/13 at iew indicated the following: and and it his peer, ieft arm by the shoulder. If the group home and ran iouse. Staff was able to see is group home but since she present she was not able to ack to the home. Staff was iouse in the content of th	Wo	TAG 00154	W154Program Director will be retrained on Indiana MENTOR policy and procedures on Investigations. This includes, is not limited to what needs to investigated, and how to complete investigations, and ensuring that all investigations are thoroughly completed. This includes ensuring that all factu findings correspond with each other, and that all areas are looked into and explored. The Program Director will be retrain on following up on all recommendations made from results of the investigations. Ongoing, the Program Director will ensure that all required investigations are completed accurately, appropriately, within the correct time frame, and according to Indiana MENTOR policy. Ongoing, all investigation will be reviewed by the Area Director and/or the Quality Assurance Manager for accurated and recommendations. Direct Care Staff will be retrained on Indiana MENTOR's reporting procedures, including but not limited to abuse, neglect, and exploitation, and all other reportable incidents according BDDS. The Home Manager are	is but be sal ned the or in R's instancy	
	indicated, "The PI	O (Program Director) will			_		
	investigate the inc	· •			Program Director will be retrain		
					on Indiana MENTOR's reportir	ng	

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STATEMENT OF DEFIC	CIENCIES	X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	
AND PLAN OF CORREC	CTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G606	B. WIN	G		09/16/	2013
	n armer ree			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER O	OR SUPPLIER	<u>.</u>		3025 GI	REENHILLS LN S		
REM-INDIANA INC				INDIAN	APOLIS, IN 46222		
		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
,		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG REGU	LATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG			DATE
an investincident -BDDS "[Client to elope physical [client A PIA (Ph holding injured the PIA from the Investing 4/8/13 If then we the face bruising The 4/9 docume BPRNN Note) didinner, he starte E]. [Client and becagroup he was a group he was a group he was a group he collection and becagroup he collect	report date is A] was have from the glly attacking A's] behaving sical Mahim to the nor did he is [Client A is a him to the nor did he is [Client A is a him to the nor did he is [Client A is a him to the nor did he is [Client A is a him to the nor did he is [Client A is a him to the nor did he is [Client A is a him to the nor did he is a him t	ed 4/9/13 indicated, aving behaviors with trying group home as well as ang staff and clients. Due to dors two staff had to use magement) on [client A] by a ground. [Client A] was not receive any bruising from all has a history of eloping led 4/9/13 regarding the port indicated, "[Client A] lient D], punching him in bold do not having any som [client A] hitting him." In a gation did not indicate review of client A's reprogress Report Narrative B which indicated, "After thit roommate's mouth and g. [Client A] also hit [client a tooth due to the blow he			procedures, including but not limited to abuse, neglect, and exploitation, and all other reportable incidents according BDDS. Ongoing, the Direct Ca Staff, Home Manager, and Program Director will ensure the all incidents, according to BDD are reported appropriately and correctly. Addendum- Starting 10/16/2013 An Administrative staff will complete 2 weekly au of the books for four weeks. At the four weeks, the administratistaff will continue with no less than one weekly audit, ongoing to ensure that no incidents remunreported. Completion Date: October 16, 2013Responsible Party: Home Manager, Progra Director, and Area Director	nat DS, on dits fter tive	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G606	B. WIN			09/16/	2013
		I			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		ed 7/25/13 regarding the					
	_						
	7/21/13 BDDS report indicated, "On 7/20/13 [client A] eloped from the home and the						
	police were called						
	police were called.						
	The 7/25/13 Inves	stigation indicated, "Factual					
		ew with [DSP (Direct					
	_	onal) #1]; (1) the other					
	* *	h him on that day had left					
	_	0 PM; (6) he watched					
		e porch while he called the					
		cause he was the only staff					
	_	•					
		police found [client A] a					
	snort time later,	. maybe 30 minutes."					
	The 7/25/12 Inves	stigation indicated,					
	_	DSP #3]; (1) she left her					
		(2) She had been there since					
	9:00 AM."						
	The facility's Tim	ne Detail form dated 9/10/13					
		9/11/13 at 8:00 AM. The					
	•	etail form dated 9/10/13 worked from 12:00 PM					
	through 8:00 PM	on //20/13.					
	The 7/25/12 Invo	stigation did not indicate the					
		wed the Time Detail form to					
		1 and #3's statements					
		s's presence in the home					
		ring the incident if she was					
	on duty in the hor	ne.					
	_RDDS raport dat	ted 8/26/13 indicated, "In					
	-	23/13, [client A] became					
	_	-					
		nd eloped from the group					
	nome. [Client A]	ran straight to a neigbors					

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
ANDILAN	OF CORRECTION	15G606		LDING	00	09/16/	
		133000	B. WIN			09/10/	2013
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				REENHILLS LN S APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` '	arted banging on the door					
	-	ent A] has a history of					
	_	e elopes. The neigbor (sic)					
	•	started verbally threatening					
		staff member that was					
	*	called the police and staff					
		nt back to the group home					
	-	arrived. The neighbor					
		ck to the group home and					
		erbally threatening. The					
	-	took the neighbor back to					
	_	te to him in private. While the neighbor's [client A]					
		e again but staff were able					
		o staying in the house. The					
		ortly afterwards and stated					
	-	ded to stay in the home and					
		the neighbor's property					
	_	't prevent any negative					
		uld be trespassing."					
	-Investigation date	ed 8/28/13 regarding the					
	_	ndicated, "On 8/23/13					
		from the home and went to					
	a neighbor's home						
	C						
		tigation indicated, "Factual					
	_	w with [DSP #1]: (1) the					
		g with him on that day					
		their shift at 9:00 PM; (2)					
		g snack [client A] went to					
	· · · · · · · · · · · · · · · · · · ·	ch is where he spends the					
		ne; (3) at approximately					
		[client A] screaming, 'leave					
		e went to the basement to					
		ippened; (5) [client A]					
	uiu not express wi	nat was wrong, but he did					

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	of Correction identification number: 15G606	A. BUILDING	00	COMPLETED 09/16/2013
	PROVIDER OR SUPPLIER	3025 GR	DDRESS, CITY, STATE, ZIP CODE	1 22:12:2
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	APOLIS, IN 46222 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	calm down; (6) he was in the kitchen 5 minutes later when [client A] came upstairs and bolted out (of) the kitchen door; (7) he attempted to grab [client A] to prevent him from leaving but [client A] was to (sic) fast; (8) he watched [client A] from the porch while he called the [HM (Home Manager) #1] because he was the only staff available: (9) he observed [client A] approach a neighbor's home but he did not know what [client A] was doing; (10) he observed [client A] being chased back to his home by a male waving a bat; (11) [client A] went in to the house; (12) the man was very upset stating [client A] was pounding on his door; (13) he would hit [client A] and the staff if they were found on his property again; (18) the on call supervisor arrived at approximately 10:00 PM" The 8/28/13 Investigation indicated, "Interview with [DSP #2]; (1) she worked at the group home from 2:00 PM until 10:00 PM on 8/23/13; (2) there were no issues that day and everything was fine when she left." The 8/28/13 Investigation indicated, "Interview with [HM #1]; (1) she arrived at the home at approximately 9:30 PM; (2) there were two police officers completing a report when she arrived; (3) the police explained that the [neighbor #1] is (sic) very upset; (4) the officers stated the [neighbor #1] had a bat and was threatening to harm [client A] and staff and the neighbor did have the right to defend himself."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		15G606	B. WIN	IG		09/16/20	13
NAME OF F	ROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
					REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CO CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	TI 0/20/12 I						
		stigation indicated,					
		Evidence does not support					
		oped; (2) Evidence supports					
	stari responded qu	nickly and appropriately."					
	The facility's Time Detail form dated 9/10/13						
	•	9/11/13 at 8:00 AM. The					
		tail form dated 9/10/13					
		worked at the group home					
		ough 11:00 PM on 8/23/13.					
	The 8/28/13 Inves	stigation did not indicate the					
	facility had review	ved the Time Detail form to					
	reconcile DSPs #1	and #2's statements					
	regarding DSP #2	's presence in the home					
	and/or actions dur	ring the incident if she was					
	on duty in the hon	ne. The 8/28/13					
	Investigation did 1	not indicate documentation					
	regarding if the st	affing levels in the home					
	were adequate to	provide client A's identified					
	level of supervision	on.					
		was reviewed on 9/10/13 at					
		A's BPRNN dated 3/30/13					
		client A] ate dinner [client					
	- ' '	np around the living room					
	` '	ommate (sic) is [Client					
	_	ate the roommate (sic)					
	_	ne alone (sic) [client A] hit					
		and time. Then run away					
	` '	(Police Department) then					
	, ,	Client A] runs away (sic)					
	· '	ghbor's house (and) bang on					
	` '	and) scream(ing)." Client					
		1 3/30/13 indicated, "Staff					
	call (sic) 911 then	when (sic) back house (to)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED	
		15G606	B. WIN			09/16/2013	
NAME OF D	PROVIDER OR SUPPLIER	•	_	STREET A	DDRESS, CITY, STATE, ZIP CODE	-	
NAME OF P	RO VIDER OR SUFFEIER	•			REENHILLS LN S		
	DIANA INC			<u> </u>	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		i
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		(sic) 911 came go there					
	` /	t A]. Later they bring him					
	back home."						
	Client A's DDDNIN	N dated 4/8/13 indicated,					
		ent A] hit roommate's					
		ted bleeding. [Client A]					
		[Client D] lost a tooth due					
		eived from [client A]."					
	to the blow he lee	orrow from [onone 11].					
	2. The facility's B	DDS reports and					
	•	re reviewed on 9/9/13 at					
	_	iew indicated the following:					
		2					
	-BDDS report date	ed 8/29/13 indicated,					
	_	eeting on 8/26/13, [client					
	D's] brother repor	ted that [client D] was					
	physically attacke	d by his roommate [client					
	A] on 8/24/13." T	he 8/29/13 BDDS report					
	indicated the date	of knowledge of the					
	allegation of abuse	e regarding client D was					
	8/26/13.						
	`	r) #1 was interviewed on					
		PM. When asked if					
	-	ndividual that results in					
		d supervision as described					
		th and welfare considered					
		ated, "Yes." When asked if					
	•	apport for an individual					
		ate supervision with the					
	•	ficant harm or injury to an					
	individual was neg	glect, AD #1 stated, "Yes."					
	AD #1 was intervi	iewed on 9/10/13 at 12:50					
		ated allegations of abuse,					
		nent, exploitation and					
	,	, . r	1			1	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606			(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE : COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER DIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR injuries of unknow thoroughly investi AD #1 was interv PM. AD #1 indica records should be statements. AD #1 should determine working at the time	iewed on 9/12/13 at 1:00 ated the facility's time detail reconciled with staff's indicated investigations who was in the home	III PRE)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	9-3-2(a)						

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Event ID: HIKE11

Facility ID: 001175

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PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606			LDING G	ONSTRUCTION 00	(X3) DATE : COMPL 09/16/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S		
REM-IND	IANA INC				IAPOLIS, IN 46222		
(X4) ID PREFIX TAG W000158	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	FACILITY STAFF The facility must estaffing requirement Based on record facility failed to a sampled clients (facility failed to (Qualified Intelled Professional) cook (Behavior Supportestitution for proneighbor's windown ensure the QIDP C and D's programeasurable data failed to ensure the A, B, C and D's Functional Assessannually. The fact there were adequimplement client Findings include 1. The QIDP fail A's BSP regarding destruction of a required program data collection. The program data collection of a program data collection. The program data collection of a program data collection. The program data collection of a program data collection. The program data collection of a program data collection of a program data collection. The program data collection of a program data collection of a program data collection.	ensure that specific facility ents are met. review and interview, the meet the Condition of cility Staffing for 4 of 4 A, B, C and D). The ensure the QIDP ectual Disabilities ordinated client A's BSP ent Plan) regarding operty destruction of a low. The facility failed to monitored clients A, B, ens in regard to collection. The facility the QIDP ensured clients CFAs (Comprehensive esements) were reviewed ceility failed to ensure late staff levels to A's BSP.	W0	00158	W158Program Director will be retrained on correctly implementing the Behavior Support Plan specifically writte for each Client A, specifically restitution portion. The restitut plan that was not previously implemented will be completed. Ongoing, the Program Director will implement all BSI the way the team intended. The Program Director will also ensure that ongoing training is availated and completed with the Direct Care Staff, as to ensure that the BSP is completed correctly at times. Addendum-Starting on 10/16/2013 An Administrative staff will complete 2 weekly observations for four weeks. At the four weeks, the administrative staff will continue with no less than one weekly observation ongoing, to ensure that all BS are being utilized and complete appropriately. The Home Manager will be retrained on ensuring that monthly data collection sheets are located in the home, and that staff are appropriate running, tracking, documenting each goal being This includes working with the Program Director to ensure the new goal tracking sheets are placed in the home at the beginning of each month. Ongoing, the Program	en the tion ram ne ture tole the all After tive Ps ted and ran.	10/16/2013

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Event ID: HIKE11

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G606	B. WING		09/16/2013
NAME OF E	PROVIDER OR SUPPLIER		STREET .	ADDRESS, CITY, STATE, ZIP CODE	-
TWINE OF F	NO VIDER OR BUILDER			REENHILLS LN S	
REM-IND	DIANA INC		INDIAN	IAPOLIS, IN 46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		5.112
	_	iled to ensure there were		Director and Home Manager vensure that the goal tracking	VIII
	_	vels to implement client		sheets are located in the home	Δ
	A's BSP. Please	see W186.		throughout the duration of the	I
				month.Addendum- Starting on	I
	This federal tag	relates to complaint		10/16/2013 An Administrative	
	#IN00135534.			staff will complete 2 weekly au	I
				of the books for four weeks. A the four weeks, the administra	
	9-3-3(a)			staff will continue with no less	uvC
				than one weekly audit, ongoin	g,
				to ensure that all goal tracking	·
				sheets are made available to t	the
				staff, are completed, and documented correctly. The	
				Program Director will be retrai	ned
				on completing Comprehensive	
				Functional Assessments and	
				ensuring that they do not expire	re.
				This retraining will include	
				appropriately completing these assessments, and ensuring th	
				they are available at all times	
				reference.Ongoing, the Progra	
				Director will ensure that all CF	
				are completed in a timely man	ner
				and are available when	
				needed.Please also see W159The Home Manager and	
				Program Director will be retrai	
				on appropriate staffing levels	
				according to each client's nee	ds,
				including but not limited to,	
				meeting the needs of each	ing
				Behavior Support Plan. Ongo the Home Manager and Progr	_
				Director will ensure that the	u
				appropriate staffing is in place	for
				each client. Addendum- Starti	ng
				on 10/16/2013 An Administrat	ive
				staff will complete 2 weekly	ftor
				observations for four weeks. A	AILEI

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		IDENTIFICATION NUMBER: 15G606	A. BUILDING B. WING		COMPLETED 09/16/2013	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
	IANA INC		INDIAN	REENHILLS LN S IAPOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	the four weeks, the administra staff will continue with no less than one weekly observation ongoing, to ensure that appropriate staffing is in place Please also see W186Comple Date: October 16, 2013Responsible Party: Home Manager, Program Director, at Area Director	tive tion	

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING COMPLET			ETED
		15G606	A. BUIL B. WING			09/16/	2013
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PRO	OVIDER OR SUPPLIER						
DEM INDI	ANIA INIC				REENHILLS LN S		
REM-INDIA	ANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000159	REGULATORY OR 483.430(a) QUALIFIED MEN PROFESSIONAL Each client's activ be integrated, coc a qualified mental Based on record 4 of 4 sampled cl the QIDP (Qualified) Disabilities Profe coordinate client Support Plan) reg property destruct window. The QII clients A, B, C ar regard to measur QIDP failed to e D's CFAs (Comp Assessments) we Findings include 1. Client A's reco 9/10/13 at 9:11 A Management Ass (RMAP) form da following: -"[Client A] has a Revision: 10/12/ from the home an away from staff.'	TAL RETARDATION The treatment program must ordinated and monitored by retardation professional. The review and interview for lients (A, B, C and D), fied Intellectual ressional) failed to the A's BSP (Behavior garding restitution for garding restitution for garding restitution for garding restitution. The resure clients A, B, C and rehensive Functional rere reviewed annually. The reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed annually. The reviewed on the reviewed on the reviewed on the reviewed annually. The reviewed on t			W159Program Director will be retrained on correctly implementing the Behavior Support Plan specifically writte for each Client A, specifically trestitution portion. The restitut plan that was not previously implemented will be completed. Ongoing, the Program Director will implement all BSF the way the team intended. The Program Director will also ensure that ongoing training is available and completed with the Direct Care Staff, as to ensure that the BSP is completed correctly at times. Addendum-Starting on 10/16/2013 An Administrative staff will complete 2 weekly observations for four weeks. At the four weeks, the administra staff will continue with no less than one weekly observation ongoing, to ensure that the BS is being utilized correctly. 2. The Home Manager will be retrained on ensuring that monthly data collection sheets are located in the home, and the staff are appropriate running, tracking, and documenting each goal being ran. This includes working with the Program Director ensure that new goal tracking sheets are placed in the home the beginning of each	en he ion am o le ure ole all after tive SP is hat octoring	

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Event ID: HIKE11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
		15G606	B. WIN			09/16/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
		TAMENTA OF DEPLOYED VOICE				I	Q15)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		IAU	month.Ongoing, the Program		DATE
					Director and Home Manager v	vill	
		of Indiana Mentor to			ensure that the goal tracking	VIII	
	prepare a BSP d	esigned to develop and			sheets are located in the home	е	
	teach adaptive b	behaviors to [client A] for			throughout the duration of the		
	the purpose of ir	nproving his quality of			month.Addendum- Starting on		
		ce and meaningful			10/16/2013 An Administrative		
	participation in t	_			staff will complete 2 weekly au		
	ration in t				of the books for four weeks. A		
	"Target for rad	action: (2) Property			the four weeks, the administra staff will continue with no less	uve	
	_	action: (3.) Property			than one weekly audit, ongoin	a.	
	destruction. Attempting to or actually				to ensure that all goal tracking		
	smashing, ripping, disassembling,				sheets are made available to t		
	slamming, throw	ving, marring or otherwise			staff, are completed, and		
	defacing non-dis	scarded property."			documented correctly. Please		
					also see W2523. The		
	-"Target for redu	action: (8.) Elopement.			Program Director will be retrait on completing Comprehensive		
	Runs/Wanders a	• • •			Functional Assessments and	;	
					ensuring that they do not expir	re.	
	-"Responding to	: Destroys Property: (6.)			This retraining will include		
		roduced and the repair or			appropriately completing these	Э	
		_			assessments, and ensuring th		
	•	t exceeded \$10.00 contact			they are available at all times		
	` •	n Director)/QIDP			reference.Ongoing, the Progra Director will ensure that all CF		
	` -	ectual Disabilities			are completed in a timely man		
	Professional). The	he IST (Interdisciplinary			and are available when		
	Team) may dete	rmine that [client A] must			needed.Please also see		
	establish an escr	ow account of a			W259.Completion Date: Octob	per	
	particular size fr	om which to make			16, 2013Responsible Party:		
	*	ursement for property			Home Manager, Program		
	damage."				Director, and Area Director		
	damage.						
	"Fach payday [client Al must then					
		client A] must then					
		of this net pay until the					
		the size specified by the					
	_	ccurrence of property					
	destruction, the	PD must assess the extent					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		LDING	NSTRUCTION 00	(X3) DATE COMPL 09/16/	ETED	
	PROVIDER OR SUPPLIER		3025 GF	.ddress, city, state, zip code REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	cost of damaged then authorize rearrange for need assure that prope [Client A] must of replacement a escrow limit." Community Neigninterviewed on 9 stated, "We've serunning through December (2012 A] came up on non the doors and A] was banging broke one of the have the bottom panel was fixed was \$37.00. I had oit." CN #2 stated down here that do back to the house broke the windowould pay for the to the [former PI heard back from AD (Area Direct on 9/10/13 at 12 client A's BSP direstitution for pr	ricluding replacement articles. The PD must placement of goods, ed repairs to be made and er receipts are obtained. Then pay for the real cost and repairs up to the glabor (CN) #2 was /9/13 at 5:45 PM. CN #2 een him, [client A] the streets. Last), he was here. He, [client any porch and was banging screaming. He, [client on the door so hard it glass panels. I had to glass panel replaced. The on 9/2/13 and the cost d a contractor that I know ted, "The staff came ay trying to get him to go e. When he, [client A] we they said that they e damage. I tried to talk D] a few times but I never him. I have the receipts." The staff came are the staff came are the said that they end that th				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CURRECTION	15G606	A. BUILDING		00	09/16/		
		100000	B. WING	eren •	DDDEGG CITY GTATE ZID CORE	03/10/	2010	
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE			
REM-IND	DIANA INC				APOLIS, IN 46222			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		the neighbor's door being	TAG		DEFICIENCI)		DATE	
	_	stated, "Yes, if I had						
		we could have taken care						
		vare." AD #1 indicated the						
		coordinated with the						
	neighbor to ensu	re client A paid						
	-	e property he damaged.						
	2. The QIDP fai	led to monitor clients A,						
	-	ograms in regard to						
	measurable data	collection. Please see						
	W252.							
	The state of the s	led to ensure clients A, B,						
		were reviewed annually.						
	Please see W259	9.						
	This federal tag	relates to complaint						
	#IN00135534.							
	9-3-3(a)							
	(u)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED	
		15G606	B. WIN			09/16/	09/16/2013	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				REENHILLS LN S			
REM-IND	IANA INC				APOLIS, IN 46222			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	A83.430(d)(1-2) DIRECT CARE S The facility must plans. Direct care staff to mana accordance with splans. Direct care staff along 24-hour period for living unit. Based on record 1 of 4 sampled of failed to ensure the levels to implem (Behavior Support	TAFF provide sufficient direct age and supervise clients in their individual program are defined as the present ulated over all shifts in a r each defined residential review and interview for lients (A), the facility there were adequate staff ent client A's BSP ort Plan). The provide sufficient direct age and supervise clients in their individual program The provide sufficient and interview for lients (A), the facility there were adequate staff ent client A's BSP ort Plan). The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct age and supervise clients in their individual program The provide sufficient direct ag	W0		W186Home Manager and Program Director will be retrain on ensuring appropriate staffin levels are in place for each clie specifically. This includes, but not limited to, staffing in a way ensure the Behavior Support Plans are able to be appropria implemented. Client A's IDT will convene to review his level of staff needed. The Program Director will review all of Client A's documents to ensure they reflect his correct level of staffing. Ongoing, the Home Manager and Program Director will ensure that the appropriate staffing is in place for each client Addendum- Starting on 10/16/2013 An Administrative staff will complete 2 weekly observations for four weeks. A the four weeks, the administratistaff will continue with no less than one weekly observation ongoing, to ensure that appropriate staffing is in place. Completion Date: October 16,	ned ag ent is to tely II t		
		Staff saw him leave the			2013Responsible Party: Home	;		
	_	as unable to follow where			Manager, Program Director, ar	nd		
		ff called 911. Police found			Area Director			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OF CORRECTION	15G606		LDING	00	09/16/	
		130000	B. WIN			09/10/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				REENHILLS LN S APOLIS, IN 46222		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	[client A] 40 minu	ites later."					
	_	ed 8/26/13 indicated, "In					
the evening of 8/23/13, [client A] became							
	1 -	d eloped from the group					
		ran straight to a neigbors					
	` ′	arted banging on the door					
	_	ient A] has a history of					
		e elopes. The neighbor (sic)					
	_	started verbally threatening					
		staff member that was					
present. His wife called the police and staff and [client A] went back to the group home							
		arrived. The neighbor					
	_	ck to the group home and					
		erbally threatening. The					
		took the neighbor back to					
	1 -	te to him in private. While					
		the neighbor's [client A]					
	_	again but staff were able					
		o staying in the house. The					
		ortly afterwards and stated					
	-	ded to stay in the home and					
	that if he goes on	the neighbor's property					
	again, they couldn	't prevent any negative					
	effects, as this wo	uld be trespassing."					
		10/20/42					
		ed 8/28/13 regarding the					
		ndicated, "On 8/23/13					
		from the home and went to					
	a neighbor's home	.					
	The 8/28/13 Inves	tigation indicated, "Factual					
		w with [DSP #1]: (1) the					
	_	g with him on that day					
		their shift at 9:00 PM; (2)					
	· ′	g snack [client A] went to					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 09/16/	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤЕ	(X5) COMPLETION DATE
	majority of his tin 9:40 PM he heard me alone'; (4) h determine what ha did not express who calm down; (6) minutes later when and bolted out (of attempted to grab from leaving but [(8) he watched while he called the #1] because he water (9) he observed neighbor's home because he water (12) stating [client A] was doi [client A] being client A] being client A] being client A] was doingly to the house; (12) stating [client A] was doingly to the house; (12) stating [client A] was doingly to the house; (13) he would be they were found on the on call super approximately 10: The 8/28/13 Investigation on 8/23/13; (2) that day and every left." The 8/28/13 Investigation on 8/23/13; (2) that day and every left."	tigation indicated, OSP #2]; (1) she worked from 2:00 PM until 10:00) there were no issues thing was fine when she					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 15G606		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	COMPLETED 09/16/2013		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	report when she arrived; (3) the police explained that the [neighbor #1] is (sic) very upset; (4) the officers stated the [neighbor #1] had a bat and was threatening to harm [client A] and staff and the neighbor did have the right to defend himself." Client A's record was reviewed on 9/10/13 at 9:11 AM. Client A's BPRNN dated 3/30/13 indicated, "Then run away (sic) staff call PD (Police Department) then call (sic) on call. [Client A] runs away (sic) he went to the neighbor's house (and) bang on there (sic) doors (and) scream(ing)." Client A's BPRNN dated 3/30/13 indicated, "Staff call (sic) 911 then when (sic) back house (to) call on call. Later (sic) 911 came go there (sic) talk to [client A]. Later they bring him back home." Client A's ISP (Individual Support Plan) dated 11/8/12 indicated the following: -"[Client A] has a BSP developed by [agency] on 4/13/11 including the following behaviors: Type 1 resistance, compulsive SIB (Self Injurious Behavior), Inappropriate sexual behavior, property destruction, extreme irritability, temper outburst, vacating, physical assault [Client A] had four significant incidents of elopement during August and September 2011, in which it was determined that [client A] would need one to one ratio staff as well as change to his vacating component." -"Assessment of pedestrian skills: [client A] requires 24 hour supervision while out in the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED - 09/16/2013		
	PROVIDER OR SUPPLIER			3025 GF	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	-"Assessment of h twenty four hour s Client A's Risk M Plan (RMAP) for the following: -"[Client A] does outbursts and may consequences to h -"[Client A] has a Revision: 10/12/1 the home and runs staff." -"[Client A] is cur staffing ratio durin protocol will be ei in place until char (Interdisciplinary receive one to one	anagement Assessment and m dated 11/8/12 indicated have behavioral anger of not understand his actions." history of elopement. 1: [Client A] elopes from severy quickly away from Tently on one to one hig waking hours. This ffective 10/5/11 and remain higher his IDT Team). [Client A] will be supervision during all in the exception of those					
	Client A's BSP da following: -"It is the policy of a BSP designed to adaptive behavior purpose of improvements."	ted 2/20/13 indicated the If Indiana Mentor to prepare develop and teach rs to [client A] for the ving his quality of life, meaningful participation in					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		00	(X3) DATE SURVEY COMPLETED 09/16/2013			
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
	-"One on one staffing: Due to an increase in [client A's] vacating, [client A] will have one on one staffing during waking hours. One on one staffing will monitor [client A] at all times during waking hours, except during [client A's] private times in the bathroom. The one on one staff should pay special attention to [client A's] mood and behavior. If the staff member suspects [client A] is getting agitated and his behavior may escalate, attempt to redirect [client A] to an activity in an area of the house that does not have direct access to outside the home. The one on one staff should also pay special attention to [client A] when he is near any door leading the outside of the home. The staff should always be closest to the door when in a room with [client A]." -"Responding to elopement: Staff should implement the following steps regarding vacating: (1) If the staff member suspects [client A] is getting agitated and his behavior may escalate, attempt to redirect [client A] to an activity in an area of the house that does not have direct access to outside the home. (2) If staff observes [client A] attempting to leave, prompt him to stop and remain within the program area. If [client A] does as requested, resume the ongoing activity with no further comment. (3) If staff observes [client A] attempting to leave and he ignores the prompt to stop, the staff should use agency approved physical intervention techniques to prevent [client A] from leaving the home.						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		15G606	B. WIN			09/16/	/2013
NAME OF B			-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	· ·		3025 GI	REENHILLS LN S		
	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 ' '	unable to stop [client A] and					
		, the one on one staff					
	member responsible for his program must						
	exit with him and stay with him to protect						
	_	Due to [client A's] fast					
	· ·	on of his home and his					
		y damage when he vacates,					
		aff member should use					
	• • • •	physical intervention					
		[client A]. Staff should					
	attempt to keep [client A] away from the road, other homes, property and/or vehicles.						
		sary, and if additional staff					
		econd staff member should					
	exit the home and	assist the one on one staff.					
	(5b.) If [clien	nt A] and the one on one					
	staff are in eyesig	ht, the additional staff					
	member should as	ssist on foot.					
	(5c.) If [clien	at A] and the one on one staff					
	are out of eyesigh	t, the additional staff should					
		d [client A] and his one on					
	one staff to assist.						
	(5d.) If at any	y time [client A] has vacated					
	and two or more s	staff are available and in					
	[client A's] reach	they should use agency					
	approved physical	l intervention techniques to					
	stop [client A].						
	(6.) When [cl	lient A] is contained, escort					
	him to a safe loca	tion and keep him under					
	observation until	you are sure he will not					
	vacate again.						
	(7.) If you are	e unable to catch up with					
		n minutes, contact the on					
		r further instructions.					
	_	o not see [client A] leave the					
		n call supervisor as soon as					
		one and initiate search					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/16/2013		
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE	TION SHOULD BE COMPLE THE APPROPRIATE	
TAG	procedures. (9.) If at any in eyesight, immedon call supervisor (10.) If at any enter a home other will call 911 and Electronic correspondicated AD (Acclient A's advocated and the following processing the following processing the following the follow	y point [client A] attempts to or than the group home staff the on call supervisor." condence dated 9/10/13 dministrative Staff) #1 and the had discussed revision of one staffing protocol. condence dated 9/10/13 description of the protocol of the staffing protocol. condence dated 9/10/13 description of the facility implemented	TAG	DEFICIENCY)		DATE
	follow him. They	just stand on the porch and				

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-	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED 09/16/2013		
		15G606	B. WIN			09/16/	2013	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
REM-INC	DIANA INC			3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	•	try to get him or help." CN						
	· ·	ly terrifying. It happens at						
	_	ur house with our family						
		nt A] will be screaming						
		our doors, windows and						
		inside. It scares my child."						
	· ·	eems really dangerous for						
	[client A] to be run	this. There are cars on the						
	_	ly is running in the streets						
		have street lights so it stays						
	•	know, I mean [street] is						
	* *	The gets out there, it's a						
	-	asked how often client A						
	•	ne or is seen running						
		at night, CN #1 stated, "It						
	_	arts. It will be two or three						
		ybe a month or two with						
		to cycle or something. I						
	_	at least three times this						
	summer. The last t	time it happened was on						
	8/23/13. It was late	e at night, after 10:00 PM.						
	[Client A] was bar	nging on our door trying to						
	get inside. We trie	d to get him to leave but he						
	would scream and	throw himself on the						
	8	om the home came to help						
	_	#1 stated, "I am worried						
		urt. Someone might shoot						
	_	de their house. We have						
		s would attack him if he got						
	inside."							
	CN 1/2 · · ·	1 0/0/12 : 7.47						
		ewed on 9/9/13 at 5:45						
		"We've seen him, [client						
	A] running throug							
		he was here. He, [client A] rch and was banging on the						
	came up on my po	ion and was banging on the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	15G606		LDING		09/16/	
		100000	B. WIN		PROPERTY OF THE CORE	00/10/	2010
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ng. He, [client A] was		TAG	DEFICIENC!)		DATE
		or so hard it broke one of					
	the glass panels."	or so hard it broke one or					
	une grass pariers.						
	DSP #1 was interv	viewed on 9/9/13 at 6:00					
	PM. DSP #1 state	d, " usually work in the					
		PM until 11:00 PM. I've					
		t 3 months." When asked if					
		behavioral issues, DSP #1					
		elopes from the house. He					
		oor and go to like the ' DSP #1 indicated he was					
	~	me during the 7/20/13 and					
	_	of client A's elopement.					
		he had been working alone					
		g both incidents. DSP #1					
	stated, "I saw him	leave but I couldn't leave					
		. I had to go outside to					
		d the on call but I couldn't					
		m." When asked if it was					
		be in the neighbored					
		e's doors and windows, DSP ey get angry. Sometimes it					
	1 '	Maybe like 9:00 PM or					
	11	#1 stated, "The last time					
		ned the man chased him					
		‡1 indicated staff should					
	follow client A in	to the community if he					
	elopes.						
	DSD #4 was inter	viewed on 9/9/13 at 6:10					
		ated client A has eloped					
		SP #4 indicated client A					
		red while in the community.					
	DSP #5 was interv	viewed on 9/9/13 at 6:15					
		d, "[Client A] should have					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	Ì	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/16	ETED
	PROVIDER OR SUPPLIER			3025 GF	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ile in the community."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	When asked if it v	vas safe for client A to r's homes at night without					
	on 9/9/13 at 6:20 group home could and keep him safe elopement from the stated, "Yes, I thin potential for dang to get out again. I' will do. You can't react to him, [clie behavior but I have there if he does get AD #1 (Area Dire 9/9/13 at 3:52 PM had a history of elements.)	ector) was interviewed on 1. AD #1 indicated client A opement from the group					
	one to one staffing had discussed wit June 2013 about of supervision protoc staffing to 10 min asked why client abeen considered for "It was during a tichanges and I was observed that staff one on one and [c without having staff thought it might be have staff do 10 min about the staff one on the staff do 10 min about the staff d	cated client A had been on g ratio. AD #1 indicated she h client A's advocate in changing client A's cols from one to one ute status checks. When A's supervision protocol had or revision, AD #1 stated, me when we had staffing in the home quite a bit. I f weren't really doing the lient A] was doing better aff always around him. We ee better for [client A] to minutes status checks to ocation and allow him so					

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AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 15G606			COMPLETED 09/16/2013				
		150000	B. WIN			09/10/	2013	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
REM-IND	DIANA INC			3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	*	ut staff always with him."						
		lient A's BSP dated 2/30/13						
	-	ted to reflect the 6/28/13						
		; it was in the process of						
		D #1 indicated staff should						
		0/13 BSP to ensure client						
	-	ervision protocol was						
	implemented.							
	AD #1 was intervi	lewed on 9/10/13 at 12:30						
		If one staff working in the						
		implement client A's						
	U 1	ensure client A is monitored						
		nunity, AD #1 stated, "No,						
		in the home cannot						
	_	P, it still says if at any point						
	_	e or attempts to enter a						
	house staff should	follow and prevent with						
	PIA if possible." V	When asked if client A was						
	considered to be a	t risk while in the						
	community unsup	ervised, AD #1 stated,						
		d if there should be enough						
	_	e group home to provide						
		ervices to that individuals						
		selves, others, or destroy						
		tated, "Yes." When asked if						
		eds identified by client A's						
		e provided, AD #1 stated,						
	"Yes."							
	This federal tag t	relates to complaint						
	#IN00135534.	oraco to compranit						
	π11 100133334.							
	9-3-3(a)							
	, , , , (u)							
							[

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	TED
		15G606	A. BUII B. WIN			09/16/2013	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	IANA INC				IAPOLIS, IN 46222		
			1		7.4 OLIO, IIV 40222		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	+	DATE
W000252	483.440(e)(1) PROGRAM DOC	LIMENTATION					
		ccomplishment of the					
		in client individual program					
		ust be documented in					
	measurable terms						
	Based on record	review and interview for	W0	00252	W252Home Manager will be		10/16/2013
	4 of 4 sampled c	lients (A, B, C and D),			retrained on ensuring that		
	the QIDP (Quali	* * * * * * * * * * * * * * * * * * * *			monthly data collection sheets		
	Disabilities Profe	essional) failed to			are located in the home, and the staff are appropriate running,	nat	
	monitor clients A	A, B, C and D's programs			tracking, and documenting each	ch	
		surable data collection.			goal being ran. This includes		
	<i>3</i>				working with the Program Direct		
	Findings include:			to ensure that new goal trackir	-		
	i mamgs merade	•			sheets are placed in the home	at	
	1 (1)	1			the beginning of each month.Ongoing, the Program		
		ord was reviewed on			Director and Home Manager w	_{vill}	
		AM. Client A's ISP			ensure that the goal tracking		
		ort Plan) dated 11/8/12			sheets are located in the home	9	
		A had formal training			throughout the duration of the		
	objectives to:				month.Addendum- Starting on		
					10/16/2013 An Administrative staff will complete 2 weekly au	ıdite	
	-"Will assist in p	reparing part of the			of the books for four weeks. At		
	morning, noon o	r evening meal 3 times			the four weeks, the administra		
	weekly with no r	nore than one verbal			staff will continue with no less		
	_	ff with 90% success."			than one weekly audit, ongoing		
	1 1				to ensure that all goal tracking		
	-"Will increase h	nis medication skills by			sheets are made available to t staff, are completed, and	ne	
		f water for the medication			documented correctly.		
	pass 90% indepe				Completion Date: October 16,		
	pass 5070 macpe				2013Responsible Party: Home		
	_"Will clean his !	bedroom (vacuum, dust,			Manager, Program Director, a	nd	
					Area Director		
	· ·	on more that one verbal					
	prompt with 90%	o success."					
	N777'11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
	-"Will brush his	teeth two times daily					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE S COMPL	
		15G606	A. BUI B. WIN	LDING G		09/16/	2013
	PROVIDER OR SUPPLIER			3025 GF	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		an one verbal prompt ic) 95% success."					
	purchase one tim	store and make a ne per week with no more prompt with a 70%					
	tracking sheets f	I did not indicate ISP goal for the month of August e date of review 9/10/13 dectives.					
	9/10/13 at 1:24 I	ord was reviewed on PM. Client B's ISP dated client B had formal es to:					
		week, will identify a quarter with three or less n 80% of trials."					
	30 minutes of ph	week, will participate in aysical fitness with 3 or less in 70% or less of					
		nb her hair with two or less in 80% of trials."					
	<u>-</u>	ke her bed or strip her bed with two verbal prompts f trials."					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G606	A. BUI B. WIN	LDING IG		09/16/	2013
NAME OF I	PROVIDER OR SUPPLIER		Б. WП		ADDRESS, CITY, STATE, ZIP CODE		
		· ·			REENHILLS LN S		
	DIANA INC			<u> </u>	APOLIS, IN 46222		715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	-"Five days a we	eek, will obtain her tennis					
	shoes to wear to work with three verbal						
	prompts 70% of	trials."					
	-Daily, will take a bath with three verbal						
	prompts or less i						
		l did not indicate ISP goal					
		or the month of August					
	2013 through the date of review 9/10/13 for client B's objectives.						
	Tor chefit B's obj	cetives.					
	3. Client C's record was reviewed on						
	9/10/13 at 12:08 PM. Client C's ISP dated						
	8/30/12 indicated	d client C had formal					
	training objectiv	es to:					
	"Daily during l	nygiene will gather all of					
	1	olies for his shower with					
		al prompts in 70% of					
	trials."	1					
		week, will identify a dime					
		two verbal prompts or					
	less in 70% of tr	iais.					
	-"Once a week,	will take his laundry					
	basket to the was	sher with one verbal					
	prompt or less in	n 70% of trials."					
		h					
		hower time, will wash his s) thoroughly with his					
		shcloths with two or less					
	verbal prompts i						
	r						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G606	B. WIN	IG		09/16/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIER			3025 GI	REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-"Three times a	week, will set the					
	temperature on t	he oven with two verbal					
	prompts or less i	n 70% of trials."					
	-"Three times a	week, will complete an					
		hoice for 30 minutes					
	independently in						
	Client C's record did not indicate ISP goal tracking sheets for the month of August						
	2013 through the date of review 9/10/13						
	for client C's obj	ectives.					
	4 (21) - 151						
		ord was reviewed on					
		AM. Client D's ISP					
	dated 1/19/13 inc	dicated client D had					
	formal training of	objectives to:					
	-"Twice a week,	will prepare a side dish					
	with two verbal	prompts or less in 80% of					
	trials."						
	-"Three times pe	er week, will count out					
	\$1.00 worth of c	hange with three verbal					
	prompts or less i	_					
	 -"Daily during m	norning hygiene, will					
	obtain a clean ha						
	oomin a cican na	makoromor.					
	_"Three times or	week, will state the four					
		ddress with 3 verbal					
		duress with 5 verbal					
	prompts."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HIKE11

Facility ID: 001175

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606 A. BUILDING B. WING			COMPLETED 09/16/2013			
PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS. IN 46222		
SUMMARY ST (EACH DEFICIENCE REGULATORY OR -"Daily, will eng choice." Client D's record tracking sheets for 2013 through the for client D's obj AD (Area Direct on 9/10/13 at 1:4 ISP objectives she the shifts, days at by each objective was no additional	ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age in an exercise of his I did not indicate ISP goal or the month of August e date of review 9/10/13 ectives. or) #1 was interviewed or PM. AD #1 indicated hould be documented on and/ or weeks as described e. AD #1 indicated there		G STREET A 3025 GI			(X5) COMPLETION DATE

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Event ID: HIKE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		DNSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G606	B. WIN			09/16/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000259	At least annually, functional assess be reviewed by the relevancy and up. Based on record 4 of 4 sampled control (1) the QIDP (Quality Disabilities Profession of QIDP) (Quality Disabilities Profe	review and interview for lients (A, B, C and D), fied Intellectual essional) failed to ensure nd D's CFAs Functional Assessments) nnually.	W0	00259	W259The Program Director w be retrained on completing Comprehensive Functional Assessments and ensuring the they do not expire. This retrain will include appropriately completing these assessment and ensuring that they are available at all times for reference.Ongoing, the Progra Director will ensure that all CF are completed in a timely man and are available when needed.Completion Date: October 16, 2013Responsible Party: Home Manager, Progra Director, and Area Director	at ning s, am 'A's	10/16/2013

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Event ID: HIKE11

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PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMPI 09/16	LETED
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COI REENHILLS LN S	DE	
REM-IND	DIANA INC			APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	annually.					
	annually. 9-3-4(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HIKE11

Facility ID: 001175

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